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DATE OF REVIEW: 10/26/2015

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Full body bone scan.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

M.D. Board Certified in Occupational Medicine and Urgent Care.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY [SUMMARY]

The claimant has filed a claim for chronic ankle pain, hip pain, paresthesias, and headaches reportedly associated with an industrial injury of xx/xx/xx.
In a Utilization Review report dated xxxxx, the claims administrator denied a full body bone scan. The claimant and/or attending provider subsequently appealed.
In a Utilization Review report dated xxxxx, the claims administrator again went on to deny the full body scan. The claims administrator referenced a xxxxx office visit in its determination.

On xxxx, the claimant reported left hand numbness, left leg pain, difficulty walking, parathoracic pain, low back pain, and left ankle pain, reportedly severe. The attending provider stated that the bone scan was being sought to try and localize an area to study. The claimant stated that she lost weight, although her weight was not measured in the clinic. The attending provider suggested that claimant might be suffering from intracerebral pathology versus chronic subdural hematoma versus brain tumor, versus cranial nerve injury. A bone scan of the whole body was sought, along with CT imaging of the brain with and without contrast. The claimant had an indwelling cardiac pacemaker, it was reported.
On xxxxx, MR angiography of the brain and a CT scan of the head were sought. Norco was endorsed. The claimant's work status was not detailed. The claimant was described as walking reasonably well despite complaints of neck pain, left arm pain, vertigo, and dysesthesias about the fifth cranial nerve. The claimant exhibited normal memory, speech, and comprehension.

ANALYSIS FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION AND EXPLANATION OF THE DECISION. INCLUDE CLINICAL BASIS,

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Per ODG references the requested "Full body bone scan" is not medically necessary. ODG's Chronic Pain Chapter CRPS, Diagnostic Tests topic, states that the routine usage of bone scanning is deemed "not recommended." Here, the attending provider's documentation did seemingly suggest that the testing in question was being employed for routine evaluation purposes, without any clearly formed intention of acting on the results of the same. The attending provider stated on xxxxx that he had ordered bone scan to try and "localize an area to study." It did not appear, thus, that the attending provider in fact suspected a bona fide diagnosis of complex regional pain syndrome. The fact that CT imaging of the brain, MR angiography of the head and neck, and numerous other diagnostic tests were ordered and office visits of xxxx and xxxxx strongly suggested that the full body bone scan at issue was in fact being employed for routine evaluation purposes, without a clearly formed intention of acting on the results of the same. The attending provider did not clearly state what was suspected and/or how the full body bone scan would influence or alter the treatment plan. Therefore, the request was not medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- ☐ INTERQUAL CRITERIA
- ☐ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- ☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- ☐ TEXAS TACADA GUIDELINES
- ☐ TMF SCREENING CRITERIA MANUAL
- ☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- ☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES